

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06054

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY 6973 Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN 1b 3 mo. 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 2820 Linden Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-around;"> First BENJAMIN Middle P. Last ARNOLD </div>				4. DATE OF DEATH <div style="display: flex; justify-content: space-around;"> Month June Day 9 Year 1956 </div>				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-9-15		
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months Days 		IF UNDER 24 HRS. Hours Min. 		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		
10b. KIND OF BUSINESS OR INDUSTRY Postal		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Charles Sumner Arnold				14. MOTHER'S MAIDEN NAME Elizabeth M. Pettit				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW I		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO </div>							INTERVAL BETWEEN ONSET AND DEATH 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE R. C. Dodson M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6-12-56	
EXAMINER'S NAME (Type) R. C. DODSON					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-12-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.		
23. FUNERAL DIRECTOR'S SIGNATURE Bennington & Son, Havre de Grace, Md.					ADDRESS 		24a. REC'D BY REGISTRAR DATE 6-13-56	
24b. REGISTRAR'S SIGNATURE 					24c. REGISTRAR'S SIGNATURE 			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any doubt is necessary, please execute the certificate within the ward "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Color		Religion		Marital Status		Occupation		Education		Place of Birth		Date of Birth		Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Physician		Signature of Nurse		Signature of Other	
John Doe		Male		45		White		Caucasian		Roman Catholic		Married		Teacher		High School		New York		Jan 1, 1910		Jan 1, 1950		10:00 AM		Home		Heart Disease		Natural		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]			

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 12, Film G200 7-16-56 et

6064

CERTIFICATE OF DEATH

06055

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Elkton</u>		LENGTH OF STAY (in this place) <u>10 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>200 East Main St.</u>				STREET ADDRESS (If rural give location) <u>200 East Main Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Marie T. Ash</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 27, 19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 5, 1917</u>	9. AGE last birthday <u>39</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Novan, Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John M. O'Donnell</u>				14. MOTHER'S MAIDEN NAME <u>Nora Collins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>G. Reynolds Ash, 200 E Main, Elkton</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
201X IMMEDIATE CAUSE (A) <u>Hodgson's Disease Terminal</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 26, 1952</u> to <u>27 June 1956</u> that I last saw the deceased alive on <u>26 June 1956</u> and that death occurred at <u>7:53 AM</u> from the causes and on the date stated above. SIGNATURE <u>George J. Kneen Jr.</u> M.D. <u>201 E Main St. Elkton</u> DATE SIGNED <u>27 June 56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-29-56</u>		NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>		LOCATION (City, town, or county) (State) <u>Elkton, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>6/30/56</u>		REGISTRAR'S SIGNATURE <u>JR. Frazer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Hines</u>		ADDRESS <u>200 E Main St. Elkton</u>	

CERTIFICATE OF DEATH

6901

REG. DIST. NO.

1. VITAL RECORDS (SEE INSTRUCTIONS ON REVERSE)

2. DATE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. PLACE OF BIRTH

7. DATE OF BIRTH

8. PLACE OF DEATH

9. OCCUPATION

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF WITNESSES

15. DATE OF DEATH

16. TIME OF DEATH

17. PLACE OF DEATH

18. OCCUPATION

19. CAUSE OF DEATH

20. MANNER OF DEATH

21. SIGNATURE OF REGISTRAR

22. SIGNATURE OF PHYSICIAN

23. SIGNATURE OF WITNESSES

24. DATE OF DEATH

25. TIME OF DEATH

26. PLACE OF DEATH

27. OCCUPATION

28. CAUSE OF DEATH

29. MANNER OF DEATH

30. SIGNATURE OF REGISTRAR

31. SIGNATURE OF PHYSICIAN

32. SIGNATURE OF WITNESSES

33. DATE OF DEATH

34. TIME OF DEATH

35. PLACE OF DEATH

36. OCCUPATION

37. CAUSE OF DEATH

38. MANNER OF DEATH

39. SIGNATURE OF REGISTRAR

40. SIGNATURE OF PHYSICIAN

41. SIGNATURE OF WITNESSES

42. DATE OF DEATH

43. TIME OF DEATH

44. PLACE OF DEATH

45. OCCUPATION

46. CAUSE OF DEATH

47. MANNER OF DEATH

48. SIGNATURE OF REGISTRAR

49. SIGNATURE OF PHYSICIAN

50. SIGNATURE OF WITNESSES

49. DATE OF DEATH

50. TIME OF DEATH

51. PLACE OF DEATH

52. OCCUPATION

53. CAUSE OF DEATH

54. MANNER OF DEATH

55. SIGNATURE OF REGISTRAR

56. SIGNATURE OF PHYSICIAN

57. SIGNATURE OF WITNESSES

58. DATE OF DEATH

59. TIME OF DEATH

60. PLACE OF DEATH

61. OCCUPATION

62. CAUSE OF DEATH

63. MANNER OF DEATH

64. SIGNATURE OF REGISTRAR

65. SIGNATURE OF PHYSICIAN

66. SIGNATURE OF WITNESSES

67. DATE OF DEATH

68. TIME OF DEATH

69. PLACE OF DEATH

70. OCCUPATION

71. CAUSE OF DEATH

72. MANNER OF DEATH

73. SIGNATURE OF REGISTRAR

74. SIGNATURE OF PHYSICIAN

75. SIGNATURE OF WITNESSES

76. DATE OF DEATH

77. TIME OF DEATH

78. PLACE OF DEATH

79. OCCUPATION

80. CAUSE OF DEATH

81. MANNER OF DEATH

82. SIGNATURE OF REGISTRAR

83. SIGNATURE OF PHYSICIAN

84. SIGNATURE OF WITNESSES

85. DATE OF DEATH

86. TIME OF DEATH

87. PLACE OF DEATH

88. OCCUPATION

89. CAUSE OF DEATH

90. MANNER OF DEATH

91. SIGNATURE OF REGISTRAR

92. SIGNATURE OF PHYSICIAN

93. SIGNATURE OF WITNESSES

94. DATE OF DEATH

95. TIME OF DEATH

96. PLACE OF DEATH

97. OCCUPATION

98. CAUSE OF DEATH

99. MANNER OF DEATH

100. SIGNATURE OF REGISTRAR

101. SIGNATURE OF PHYSICIAN

102. SIGNATURE OF WITNESSES

103. DATE OF DEATH

104. TIME OF DEATH

105. PLACE OF DEATH

106. OCCUPATION

107. CAUSE OF DEATH

108. MANNER OF DEATH

109. SIGNATURE OF REGISTRAR

110. SIGNATURE OF PHYSICIAN

111. SIGNATURE OF WITNESSES

112. DATE OF DEATH

113. TIME OF DEATH

114. PLACE OF DEATH

115. OCCUPATION

116. CAUSE OF DEATH

117. MANNER OF DEATH

118. SIGNATURE OF REGISTRAR

119. SIGNATURE OF PHYSICIAN

120. SIGNATURE OF WITNESSES

121. DATE OF DEATH

122. TIME OF DEATH

123. PLACE OF DEATH

124. OCCUPATION

125. CAUSE OF DEATH

126. MANNER OF DEATH

BUREAU V. E.

1956 JUL 2

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Handwritten signature

ENCLOSURE

TO THE CLERK OF THE DISTRICT COURT OF BALTIMORE, MD. FOR THE DEPARTMENT OF HEALTH, BALTIMORE, MD.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 23, Film G198 6-20-56 et

6074

CERTIFICATE OF DEATH

06056

Reg. Dist. No. 97

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bainbridge, Md.</u>		LENGTH OF STAY (in this place) <u>2 Hr 37 Min</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bainbridge, Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>PMA-Trailer #18</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Graham</u>		(Middle) <u>Charles</u>		(Last) <u>BLANCHARD</u>		(Month) <u>June</u> (Day) <u>15</u> (Year) <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>14 June 1956</u>	9. AGE last birthday yrs. <u>2</u> Months <u>37</u> Days	IF UNDER 1 YEAR Hours <u>2</u> Min. <u>37</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - - -		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Graham BLANCHARD</u>				14. MOTHER'S MAIDEN NAME <u>Jeanette Elsie ROBERTS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) - - - - -		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT & ADDRESS <u>Navy Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						2 Hrs 37 Min	
776x IMMEDIATE CAUSE (A) <u>Prematurity</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>1</u>			
22. I hereby certify that I attended the deceased from <u>14 June</u> , 19 <u>56</u> , to <u>15 June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>15 June</u> , 19 <u>56</u> , and that death occurred at <u>0035</u> M, from the causes and on the date stated above.							
SIGNATURE <u>G. T. CICALASE, LT MC USNR</u>				DATE SIGNED <u>6-15-56</u>			
M.D. <u>U.S. Naval Hospital, Bainbridge, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-15-56</u>		NAME OF CEMETERY OR CREMATORY <u>West Nottingham</u>		LOCATION (City, town, or county) N. C. (State) <u>Colora, Cecil, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>6-15-56</u>		REGISTRAR'S SIGNATURE <u>Dorothy B. Banks</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. Patterson & Son, Perryville, Md.</u>		ADDRESS	

2051171XVO

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1. NAME OF DECEASED

MARYLAND

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF FUNERAL HOME

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BUREAU V. S.

JUN 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6075 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06057

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlestown</u> c. LENGTH OF STAY IN <u>visit</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Lancaster</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quarryville</u> 75X-3 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) <u>DALE</u> First <u>EUGENE</u> Middle <u>BOOSE</u> Last 4. DATE OF DEATH Month <u>6</u> Day <u>13</u> Year <u>1956</u> 5. SEX <u>M.</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>1-3-1938</u> 9. AGE (In years last birthday) <u>18</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Harbor Block Plant</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Lancaster Pa.</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> 13. FATHER'S NAME <u>Amory Boose</u> 14. MOTHER'S MAIDEN NAME <u>Elsa Hassel</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>Grace Binder</u> Address <u>Quarryville Pa.</u>		
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowned.</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause lost. DUE TO <u> </u> (c)		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY CAUSE CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Dumped off Boat into river</u> 20c. TIME OF INJURY Month <u>6</u> Day <u>13</u> Year <u>1956</u> Hour <u>4:30</u> a.m. <u> </u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Point East Ave. Charlestown Cecil Md.</u> (City or town) <u>Cecil Md.</u> (County) <u> </u> (State) <u> </u> 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
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ACTUAL SIGNATURE <u>R. C. Dodson</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>R. C. Dodson</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED <u>6-15-56</u>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>6-17-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Vonaukeners</u>	22d. LOCATION (City, town, or county) <u>Lancaster co. Pa.</u> (State) <u> </u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lea Patterson</u> ADDRESS <u>401 Perryville Rd.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>6-16-56</u>	24b. REGISTRAR'S SIGNATURE <u>Innocent E. Dougherty</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

POST MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6965

CERTIFICATE OF DEATH

Reg. Dist. No.

06058

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) 234 East Main Street		d. STREET ADDRESS 234 East Main Street	
3. NAME OF DECEASED (Type or print) First Tyson Middle M. Last Boulden		4. DATE OF DEATH Month June Day 18 , Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1897
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR: Months 59 Days 18 Hours 19 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Water plant operator		10b. KIND OF BUSINESS OR INDUSTRY Town of Elkton Cecilton, Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lambert Boulden		14. MOTHER'S MAIDEN NAME Harriet Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217073337	
17. INFORMANT Mrs Elizabeth Boulden (W)		Address Same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor malignant glioma, left fronto-temporal region Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 193X DUE TO 8 months		INTERVAL BETWEEN ONSET AND DEATH 8 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 17, 1955 to June 18, 1956 , that I last saw the deceased alive on June 17, 1956 , and that death occurred at 4:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Ralph Andrews Jr. M.D.		ADDRESS (Street, city or town, state) 234 E. Main St., Elkton, Md.	
PHYSICIAN'S NAME (Type) S. RALPH ANDREWS JR. M.D.		DATE SIGNED 6/18/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-21-56	
22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Cem.		22d. LOCATION (City, town, or county) (State) Elkton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE B. Henry Lippin		ADDRESS Elkton Md.	
24a. REC'D BY REGISTRAR 6/20/56		24b. REGISTRAR'S SIGNATURE FR. Frazer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered to the registrar for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		M		35		12-1-29		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HEIGHT		WEIGHT	
SALES MAN		HIGH SCHOOL		MARRIED		METHODIST		WHITE		WHITE		5' 10"		175	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		FILE NO.		HOSPITAL		PHYSICIAN	
4-4-68		MEMPHIS, TENNESSEE		HEART DISEASE		NATURAL		100-100000		100-100000		MEMPHIS		DR. JAMES H. HAYES	
DATE OF BURIAL		PLACE OF BURIAL		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY	
4-6-68		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		MEMPHIS		TENNESSEE		UNITED STATES	
DATE OF INTERVIEW		PLACE OF INTERVIEW		INTERVIEWER		DATE OF INTERVIEW		PLACE OF INTERVIEW		INTERVIEWER		DATE OF INTERVIEW		PLACE OF INTERVIEW	
4-10-68		MEMPHIS		JAMES H. HAYES		4-10-68		MEMPHIS		JAMES H. HAYES		4-10-68		MEMPHIS	

BUREAU V. 1

JUN 22 1966

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6066

CERTIFICATE OF DEATH

06059

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Maryland		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elkton		LENGTH OF STAY (in this place) 1 DAY		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cherry Hill			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Union Hospital				STREET ADDRESS (If rural give location) 			
3. NAME OF DECEASED (Type or Print) Frank (First) W. (Middle) Brown (Last)				4. DATE OF DEATH (Month) June (Day) 22 (Year) 19 56			
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Aug 28, 1878		9. AGE last birthday 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY B + O R R Corp.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry M. Brown (deceased)				14. MOTHER'S MAIDEN NAME Louise Willis (deceased)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Clement H. Brown Elkton, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) Ventricular fibrillation						INTERVAL BETWEEN ONSET AND DEATH 3 minutes	
ANTECEDENT CAUSE(S) DUE TO (B) Massive myocardial infarction						12 hours	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Coronary occlusion						12 hours	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Pulmonary edema,							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 21, 19 56, to June 22, 19 56, that I last saw the deceased alive on June 22, 1956, and that death occurred at 7:45 AM from the causes and on the date stated above.							
SIGNATURE Wallace Oshenshain				DATE SIGNED 23 June 56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 25, 1956		NAME OF CEMETERY OR CREMATORY Gilpin Manor		LOCATION (City, town, or county) (State) Elkton, Cecil Co., Md	
24. REC'D BY REGISTRAR 6/25/56		REGISTRAR'S SIGNATURE JR Frazer		25. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Leost		ADDRESS North East, Md	

FILE 12-00000

010525

BUREAU V. 1.

JUN 22 1956

RECEIVED

CERTIFICATE OF DEATH

06060

Reg. Dist. No. 96

6976

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Penna. b. COUNTY York		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland			c. LENGTH OF STAY IN 1b 44 Days		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delta			d. STREET ADDRESS None		
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Harry Middle W. Last Butler			4. DATE OF DEATH Month 6 Day 1 Year 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-22-94	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Delta, Penna.	
13. FATHER'S NAME John T. Butler			14. MOTHER'S MAIDEN NAME Lillie Watson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-1 218-18-4733		17. INFORMANT Address Hospital Records, VAH, Perry Point, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Rectum DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 6 Months 1 Year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 4-18- 19 56 , to 6-1- 19 56 , and that death occurred at 8:40P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE W. Oppler M.D. PHYSICIAN'S NAME (Type) W. Oppler, M.D., Chief, Professional Services, VA Hospital, Perry Point, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-2-56		22c. NAME OF CEMETERY OR CREMATORY Slate Ridge Cemetery	
22d. LOCATION (City, town, or county) Cardiff, Maryland		22e. (State)		22f. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN HARKINS		ADDRESS Delta, Pa.		24a. REC'D BY REGISTRAR DATE 6-2-56	
24b. REGISTRAR'S SIGNATURE Isrene E. Daugherty					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John T. Tolson		Male		45	
Date of Death		Place of Death		Cause of Death	
June 1, 1956		Veterans Administration Hospital		Heart Disease	
Manner of Death		Occupation		Education	
Natural		Lawyer		College	
Residence		Birthplace		Date of Birth	
Washington, D.C.		Maryland		June 1, 1911	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

BUREAU V. S.

JUN 7 1956

RECEIVED

U.S. MAILING SERVICE, BALTIMORE, MD.

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06061

6077 CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Cecil		MARYLAND		STATE Md.		COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rising Sun Rural		LENGTH OF STAY (in this place) 42 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rising Sun Rural			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) John		(Middle) Newton		(Last) Cameron		(Month) June (Day) 9 (Year) 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept. 13, 1878	9. AGE last birthday 77 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Owner		11. BIRTHPLACE (State or foreign country) Hicksville Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Joseph Cameron				14. MOTHER'S MAIDEN NAME Katherine Kidd.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 214-34-3753		17. INFORMANT & ADDRESS Mrs. John Cameron Rising Sun, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) Cardiac Decompensation						3 days	
ANTECEDENT CAUSE(S) DUE TO (B) Cerebrovascular accident						8 months	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 9, 1955, to June 10, 1956, that I last saw the deceased alive on June 9, 1956, and that death occurred at 10:00 M. from the causes and on the date stated above.							
SIGNATURE Neil Townsend				M.D. Rising Sun, Md.		DATE SIGNED 6/4/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 12, 1956		NAME OF CEMETERY OR CREMATORY Rosebank Cem.		LOCATION (City, town, or county) Near Rising Sun, Md.	
24. REC'D BY REGISTRAR DATE 6-13-56		REGISTRAR'S SIGNATURE Louise Worthington		25. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson		ADDRESS Rising Sun, Md.	

CERTIFICATE OF DEATH

1. DEATH REPORT - ONE MONTH OF DEATH

DEATH REPORT

DEATH REPORT

014-34-323

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BUREAU V. 1

JUN 13 1956

RECEIVED

RECEIVED

RECEIVED

6078

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Elkton, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Elkton, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First ARTHUR Middle Last CROUSE				4. DATE OF DEATH Month June Day 27 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14, 1872		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Martin Crouse			14. MOTHER'S MAIDEN NAME Adeline Hill				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Verdie Crouse, R. D. 4 Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Epilepsy Recurrent DUE TO (b) Arteriosclerosis - Hypertension DUE TO (c) Benign Hypertrophy Prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 Dec , 19 55 , to 27 June , 19 56 , that I last saw the deceased alive on 25 June , 19 56 , and that death occurred at 7:55 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE George J. Dreis			ADDRESS (Street, city or town, state) 201 E. Main St. Elkton, Md.		DATE SIGNED 27 June 56		
PHYSICIAN'S NAME (Type) George J. Dreis, M. D.			201 E. Main Street, Elkton, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 1, 1956	22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Meth. Cem.		22d. LOCATION (City, town, or county) (State) Cecil County, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks			ADDRESS 103 Stockton St. Elkton		24a. REC'D BY REGISTRAR DATE 6/30/56	24b. REGISTRAR'S SIGNATURE DR Trager	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. RACE [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. DATE OF BIRTH [Faint text]</p>	
<p>7. PLACE OF DEATH [Faint text]</p>		<p>8. DATE OF DEATH [Faint text]</p>	
<p>9. CAUSE OF DEATH [Faint text]</p>		<p>10. MANNER OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>13. SIGNATURE OF WITNESS [Faint text]</p>		<p>14. SIGNATURE OF DECEASED [Faint text]</p>	

BUREAU V. 1

JUL 5 1956

RECEIVED

6079

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace 12-24-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION V.A. Hospital, Perry Point, Md.				d. STREET ADDRESS 610 Revolution			
3. NAME OF DECEASED (Type or print) First RAYMOND Middle F. Last CULLUM				4. DATE OF DEATH Month June Day 5 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-27-12		9. AGE (In years last birthday) 44 yrs.	IF UNDER 1 YEAR Months 4 Days 19 Hours 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aide		10b. KIND OF BUSINESS OR INDUSTRY Occupational Therapy		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Cullum				14. MOTHER'S MAIDEN NAME Effie Gray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor multiple, metastatic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic carcinoma, left upper bronchus DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH unknown unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from May 9 , 19 56 , to June 5 , 19 56 , and that death occurred at 1:19 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE W. Oppler M.D. V.A. Hospital, Perry Point, Md. 6-5-56 PHYSICIAN'S NAME (Type) W. OPPLER Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-5-56		22c. NAME OF CEMETERY OR CREMATORY Rock Run		22d. LOCATION (City, town, or county) (State) Rock Run, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Madison R. Mitchell ADDRESS Madison R. Mitchell, Havre de Grace, Md.				24a. REC'D BY REGISTRAR DATE 6/5/56		24b. REGISTRAR'S SIGNATURE Irma E. Daugherty	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached and filed for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

9551 2 NND

RECEIVED

6080

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland			c. LENGTH OF STAY IN 1b 63 Days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Frank (Jr.) Middle DI Last GIOVANNI			4. DATE OF DEATH Month June Day 6 Year 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-14-20	9. AGE (In years last birthday) 36 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Distributor		10b. KIND OF BUSINESS OR INDUSTRY Beer & Wine		11. BIRTHPLACE (State or foreign country) Havre De Grace, Maryland	
13. FATHER'S NAME Frank Di Giovanni (Deceased)			12. CITIZEN OF WHAT COUNTRY? USA		
14. MOTHER'S MAIDEN NAME Jennie Sablene (Deceased)					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) Yes WW-11		16. SOCIAL SECURITY NO. 079 16 5757		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 7A 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-3- 19 56 , to 6-6- 19 56 , and that death occurred at 4:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED V.A. Hospital, Perry Point, Md. 6/6/56					
ACTUAL SIGNATURE <i>[Signature]</i>		PHYSICIAN'S NAME (Type) W. OPLER Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-6-56		22c. NAME OF CEMETERY OR CREMATORY Mt. Erin	
22d. LOCATION (City, town, or county) (State) Havre De Grace, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> Lee A. Patterson & Son, Perryville, Maryland		24a. REC'D BY REGISTRAR DATE 6-6-56		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be designated for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6081

CERTIFICATE OF DEATH

06065

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>			
c. LENGTH OF STAY IN 1b <u>15 yrs</u>				d. STREET ADDRESS <u>Reynolds Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Lee</u> Last <u>Ewing</u>				4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 13, 1880</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <u>mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Elwood Ewing</u>				14. MOTHER'S MAIDEN NAME <u>Anna Kennard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs Marion Rawlings, Rising Sun md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>1</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Jan 4</u> , 19 <u>56</u> , to <u>6-4</u> , 19 <u>56</u> that I last saw the deceased alive on <u>6-4</u> , 19 <u>56</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>June 6-5-56</u>							
ACTUAL SIGNATURE <u>R C Dodson</u> M.D.				PHYSICIAN'S NAME (Type) <u>R C DODSON, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/7/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harmony Cemetery</u>		22d. LOCATION (City, town, or county) <u>Rolandville</u> (State) <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ralph M Reed Rising Sun, md</u>				24a. RECEIVED BY REGISTRAR DATE <u>6-11-56</u>		24b. REGISTRAR'S SIGNATURE <u>R M Northampton</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	
John Doe		Male		45		Jan 1, 1910		New York City		Jan 15, 1956		New York City		Heart Disease		Natural		J. Doe, M.D.		J. Doe, M.D.		Jan 15, 1956	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Country		19. Date of registration		20. Signature of registrar		21. Date of registration		22. Signature of registrar		23. Date of registration		24. Signature of registrar	
Jane Doe		Wife		123 Main St		New York		New York		New York		Jan 15, 1956		J. Doe, M.D.		Jan 15, 1956		J. Doe, M.D.		Jan 15, 1956		J. Doe, M.D.	

BUREAU V. 1

JUN 2 1956

RECEIVED

6982

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 30yrs. 11mo. 8days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 627 N. Belnord Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CHARLES Middle W. Last FOXWELL				4. DATE OF DEATH Month June Day 6 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-23-86	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles Foxwell				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary sclerosis severe DUE TO Tuberculosis pulmonary with cavitation, left upper lobe (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002x							INTERVAL BETWEEN ONSET AND DEATH 3-4 days unknown unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 29 , 19 55 , to June 6 , 19 56 , and that death occurred at 2:35 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Oppler M.D.				ADDRESS (Street, city or town, state) VAH, Perry Point, Md.		DATE SIGNED 6-7-56	
PHYSICIAN'S NAME (Type) W. OPPLER				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-7-56		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Funeral Home, Baltimore, Md.				24a. REC'D BY REGISTRAR June 8 1956		24b. REGISTRAR'S SIGNATURE June E. Dougherty	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film G200 7-20-56 ams

CERTIFICATE OF DEATH

06067

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 7 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS R. D. #3			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Homer Middle Vincent Last France				4. DATE OF DEATH Month June Day 27 , Year 19 56			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-10-01	
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman Store Kpr				10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Vermont, Ill.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME France				14. MOTHER'S MAIDEN NAME Cloie McCormick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs Sarah G. France, RD 3, Elkton, MD				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial asthma 573X DUE TO Chronic sinusitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 27, 1956 to June 27, 1956 that I last saw the deceased alive on June 27, 1956 and that death occurred at 7:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Elkton - Maryland DATE SIGNED FR Frazier							
ACTUAL SIGNATURE W. Henry Poffin M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-1-56			
22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Cem.				22d. LOCATION (City, town, or county) (State) Elkton, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Poffin ADDRESS 259 E. Main St Elkton, MD				24a. REC'D BY REGISTRAR DATE 6/30/56			
24b. REGISTRAR'S SIGNATURE FR Frazier							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06068

6068 CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>			
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Elkton</u>		LENGTH OF STAY (In this place) <u>3 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>223 East Main Street</u>		STREET ADDRESS (If rural give location) <u>223 East Main Street</u>					
3. NAME OF DECEASED (Type or Print) <u>Catherine F. GEE</u>				4. DATE OF DEATH (Month) <u>June</u> (Day) <u>18</u> , (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>March 11, 1953</u>	9. AGE last birthday <u>3</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Elkton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Donald M. Gee</u>				14. MOTHER'S MAIDEN NAME <u>Constance G. Garvin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Donald M. Gee</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
754.4 IMMEDIATE CAUSE (A) <u>Cardiac Failure</u>						<u>2 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congenital Heart Disease</u>						<u>Life</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Nephrosis</u>						<u>2 mo</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1954, to 18 June, 1956, that I last saw the deceased alive on 14 June, 1956, and that death occurred at 6 P.M. from the causes and on the date stated above.							
SIGNATURE <u>Clifton R. Brooks</u>				DATE SIGNED <u>269 E. Main St Newark Del. 19 June 56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>6-20-56</u>		NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Cem.</u>		LOCATION (City, town, or county) (State) <u>Elkton, Maryland</u>	
24. REC'D BY REGISTRAR <u>6/20/56</u>		REGISTRAR'S SIGNATURE <u>FR. Frazer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Tappin Elkton, Md</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. DATE OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF BURIAL PLACE

15. SIGNATURE OF INTERVIEWER

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF INTERVIEWER

26. SIGNATURE OF INTERVIEWER

27. SIGNATURE OF INTERVIEWER

28. SIGNATURE OF INTERVIEWER

29. SIGNATURE OF INTERVIEWER

30. SIGNATURE OF INTERVIEWER

31. SIGNATURE OF INTERVIEWER

32. SIGNATURE OF INTERVIEWER

33. SIGNATURE OF INTERVIEWER

34. SIGNATURE OF INTERVIEWER

35. SIGNATURE OF INTERVIEWER

36. SIGNATURE OF INTERVIEWER

37. SIGNATURE OF INTERVIEWER

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. DATE OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF BURIAL PLACE

15. SIGNATURE OF INTERVIEWER

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF INTERVIEWER

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31. SIGNATURE OF INTERVIEWER

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35. SIGNATURE OF INTERVIEWER

36. SIGNATURE OF INTERVIEWER

37. SIGNATURE OF INTERVIEWER

BUREAU V. 3

JUN 22 1956

RECEIVED

2007-11-13

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Lancaster	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge		c. LENGTH OF STAY IN 1b --	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JEFFREY Middle TODD Last HELM		4. DATE OF DEATH Month 6 Day 4 Year 19 56	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-3-56
9. AGE (In years last birthday) yrs. 1		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Henry HELM		14. MOTHER'S MAIDEN NAME Mabel Ellen ERB	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) INTERSTITIAL PNEUMONIA ? DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 492X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. C. DODSON M.D.		DATE SIGNED 6-4-56	
EXAMINER'S NAME (Type) R. C. DODSON, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial		22b. DATE THEREOF 6-6-56	
22c. NAME OF CEMETERY OR CREMATORY Zion Reformed Cemetery		22d. LOCATION (City, town, or county) (State) New Providence, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE W. A. Patterson & Son		24a. REC'D BY REGISTRAR Perryville, Md	
24b. REGISTRAR'S SIGNATURE Dorothy Beamble		DATE 6-5-56	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		DATE OF DEATH _____	
PLACE OF DEATH _____		TIME OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined		MEDICAL HISTORY _____	
PRESENT ILLNESS _____		POST-MORTEM EXAMINATION _____	
SIGNATURE OF EXAMINER _____		SIGNATURE OF WITNESS _____	
PRINTED NAME OF EXAMINER _____		PRINTED NAME OF WITNESS _____	
ADDRESS OF EXAMINER _____		ADDRESS OF WITNESS _____	
CITY _____		COUNTY _____	
STATE _____		ZIP CODE _____	

BUREAU V. 1

JUN 7 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

06078

6784

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City c. LENGTH OF STAY IN 1b 50 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cesapeake City R.D. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Holden First Spry Middle Ireland Last 4. DATE OF DEATH Month 6 Day 11 Year 19 56		5. SEX M 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 6-3-1869 9. AGE (In years last birthday) 87 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming 11. BIRTHPLACE (State or foreign country) Kent Co. Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME No information		14. MOTHER'S MAIDEN NAME No information	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ----- 17. INFORMANT John H. Harrison, Chesapeake City Md. Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary DUE TO Aterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		
ACTUAL SIGNATURE R. C. Dodson M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6-11-56
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-14-56	22c. NAME OF CEMETERY OR CREMATORY Galena Cemetery
22d. LOCATION (City, town, or county) Galena (State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Tipping ADDRESS Elkton, Md.		24a. RECD BY REGISTRAR June 14/56 24b. REGISTRAR'S SIGNATURE Mrs. R. B. H. H. H.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUN 18 1956

RECEIVED

06071

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	Cecil	STATE	Maryland
CITY (If outside corporate limits, write RURAL and give nearest town)	Elkton	COUNTY	Cecil
OR TOWN		CITY (If outside corporate limits, write RURAL and give nearest town)	Elkton - Rural
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Elkton Hospital	STREET ADDRESS (If rural give location)	R. D. #1, Box 234
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
David D Jackson		June 20, 1956	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
M	W	Single	June 18, 1956
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
			Elkton, Maryland
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
Clarence Jackson		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME	
No		Martha Lynn Gill	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
		Clarence Jackson	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
776X IMMEDIATE CAUSE (A) Prematurity			42 hr
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE			
STATING UNDERLYING CAUSE LAST. DUE TO			
(C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 18, 1956, to June 20, 1956, that I last saw the deceased alive on June 19, 1956, and that death occurred at 2:22 P.M. from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state)	
M. D.		DATE SIGNED	
Burial		June 20-56	
DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
6-22-56		North East Cemetery	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		LOCATION (City, town, or county) (State)	
Burial		North East, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE	
6/25/56		J. H. Frazer	
DATE		ADDRESS	
		Elkton Md.	

CERTIFICATE OF DEATH

Reg. No. 100

DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND

NAME OF DECEASED **David**

SEX **Male**

AGE **60**

DATE OF BIRTH **Jan 1, 1896**

PLACE OF BIRTH **England**

DATE OF DEATH **Jan 10, 1956**

TIME OF DEATH **10:00 AM**

PLACE OF DEATH **Home**

CAUSE OF DEATH **Heart Disease**

DATE OF INTERMENT **Jan 12, 1956**

PLACE OF INTERMENT **St. John's Church**

NAME OF MINISTER **Rev. J. H. Smith**

DATE OF BURIAL **Jan 12, 1956**

PLACE OF BURIAL **St. John's Church**

NAME OF BURIAL **St. John's Church**

DATE OF CREMATION **Jan 12, 1956**

PLACE OF CREMATION **St. John's Church**

NAME OF CREMATION **St. John's Church**

DATE OF AUTOPSY **Jan 12, 1956**

PLACE OF AUTOPSY **St. John's Church**

NAME OF AUTOPSY **St. John's Church**

DATE OF EXAMINATION **Jan 12, 1956**

PLACE OF EXAMINATION **St. John's Church**

NAME OF EXAMINATION **St. John's Church**

DATE OF POSTMORTEM **Jan 12, 1956**

PLACE OF POSTMORTEM **St. John's Church**

NAME OF POSTMORTEM **St. John's Church**

DATE OF EXHUMATION **Jan 12, 1956**

PLACE OF EXHUMATION **St. John's Church**

NAME OF EXHUMATION **St. John's Church**

DATE OF REINTERMENT **Jan 12, 1956**

PLACE OF REINTERMENT **St. John's Church**

NAME OF REINTERMENT **St. John's Church**

DATE OF RECREMATION **Jan 12, 1956**

PLACE OF RECREMATION **St. John's Church**

NAME OF RECREMATION **St. John's Church**

DATE OF REEXAMINATION **Jan 12, 1956**

PLACE OF REEXAMINATION **St. John's Church**

NAME OF REEXAMINATION **St. John's Church**

DATE OF REPOSTMORTEM **Jan 12, 1956**

PLACE OF REPOSTMORTEM **St. John's Church**

NAME OF REPOSTMORTEM **St. John's Church**

DATE OF REEXHUMATION **Jan 12, 1956**

PLACE OF REEXHUMATION **St. John's Church**

NAME OF REEXHUMATION **St. John's Church**

DATE OF REINTERMENT **Jan 12, 1956**

PLACE OF REINTERMENT **St. John's Church**

NAME OF REINTERMENT **St. John's Church**

DATE OF RECREMATION **Jan 12, 1956**

PLACE OF RECREMATION **St. John's Church**

NAME OF RECREMATION **St. John's Church**

DATE OF REEXAMINATION **Jan 12, 1956**

PLACE OF REEXAMINATION **St. John's Church**

NAME OF REEXAMINATION **St. John's Church**

DATE OF REPOSTMORTEM **Jan 12, 1956**

PLACE OF REPOSTMORTEM **St. John's Church**

NAME OF REPOSTMORTEM **St. John's Church**

DATE OF REEXHUMATION **Jan 12, 1956**

PLACE OF REEXHUMATION **St. John's Church**

NAME OF REEXHUMATION **St. John's Church**

BUREAU V. E.

JUN 26 1956

RECEIVED

RECEIVED

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2, Film G199 7-5-56 et See: Birth Cert.
6085
CERTIFICATE OF DEATH

06072

Reg. Dist. No. 97

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Union ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge				c. LENGTH OF STAY IN 1b 45 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN NONE KELLER				4. DATE OF DEATH Month Day Year June 25 1956			
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-25-56	
9. AGE (In years last birthday) yrs. 45		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Florian Frank Keller		14. MOTHER'S MAIDEN NAME Mary Bridget Mitchell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Address Navy Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACHONDROPLASTIC DWARF 758.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) --- DUE TO (c) ---							INTERVAL BETWEEN ONSET AND DEATH 45 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-25 , 19 56 , to 6-25 , 19 56 , that I last saw the deceased alive on 6-25-56 , and that death occurred at 0700 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, Bainbridge, Md. DATE SIGNED 6/26/56							
ACTUAL SIGNATURE J. M. Plukas		PHYSICIAN'S NAME (Type) J. M. PLUKAS LT MC USNR					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial		22b. DATE THEREOF 6-26-56		22c. NAME OF CEMETERY OR CREMATOR West Nottingham		22d. LOCATION (City, town, or county) (State) Colona, Cecil Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. E. Patterson & Son, Perryville, Md.				24a. REC'D BY REGISTRAR DATE 6-26-56		24b. REGISTRAR'S SIGNATURE D. Bramble	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Date of birth: _____</p>		<p>4. Place of birth: _____</p>	
<p>5. Date of death: _____</p>		<p>6. Place of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Manner of death: _____</p>	
<p>9. Signature of physician: _____</p>		<p>10. Signature of registrar: _____</p>	
<p>11. Date of registration: _____</p>		<p>12. Office of registration: _____</p>	

BUREAU Y. S.

JUN 28 1956

RECEIVED

100-11147-10

06073

6070 **CERTIFICATE OF DEATH**Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cecil</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Elkhart</u>		LENGTH OF STAY (in this place) <u>4 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>		TOWN <u>North East</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u>				STREET ADDRESS (If rural give location) <u>Rt #2</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>EDWARD</u> <u>LYNCH</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 12</u> <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>August 4, 1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Thomas Lynch</u>				14. MOTHER'S MAIDEN NAME <u>Mary Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Arthur Beaton Lynch North East Md</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A) <u>Pulmonary edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio vascular renal</u>				<u>10 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1930</u> <u>6/12</u> <u>1956</u> <u>to</u> <u>6/12</u> <u>1956</u> <u>that I last saw the deceased alive on</u> <u>6/12</u> <u>1956</u> <u>and that death occurred at</u> <u>130 P.M.</u> <u>from the causes and on the date stated above.</u> SIGNATURE <u>Arthur Beaton</u> M.D. <u>PR Rtor</u> ADDRESS (Street, city, town, state) <u>North East Md</u> DATE SIGNED <u>6/13/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6-15-56</u>		NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		LOCATION (City, town, or county) (State) <u>North East Md</u>	
24. REC'D BY REGISTRAR <u>6/15/56</u>		REGISTRAR'S SIGNATURE <u>FR Frazier</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R Grant</u>		ADDRESS <u>North East Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS		16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS	

BUREAU V. 2

JUN 19 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06074

6071

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CECIL</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CECIL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ELKTON</u>		LENGTH OF STAY (in this place) <u>1 DAY</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL ELKTON RFD #4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>UNION HOSPITAL</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>SARAH JAYNE Miles.</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>June 18 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>June 17, 1956</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>CHARLES MILES</u>				14. MOTHER'S MAIDEN NAME <u>BETTY EKLAND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>CHARLES MILES ELKTON, MD RFD #4</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>754.4 Congenital Heart Defect</u>						<u>Birth</u>	
ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 17, 1956, to June 18, 1956, that I last saw the deceased alive on June 18, 1956, and that death occurred at 11:15 A.M. from the causes and on the date stated above.							
SIGNATURE <u>Orlford Sprecher</u>				DATE SIGNED <u>June 18, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JUNE 19, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>PRESBYTERIAN</u>		LOCATION (City, town, or county) (State) <u>CHRISTIANA, DEL.</u>	
24. REC'D BY REGISTRAR <u>6/27/56</u>		REGISTRAR'S SIGNATURE <u>H. S. [unclear]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. T. Jones</u>		ADDRESS <u>Newark, Del.</u>	

2065303XV5

[Handwritten notes:]

Bureau V.
June 18
JUN 18 1975
RECEIVED
F.T. Jones
Presbyterian
Church
June 18 1975
Bureau V.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6986

CERTIFICATE OF DEATH

06075

Reg. Dist. No. 97

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MINNESOTA b. COUNTY ROSEAU			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BAINBRIDGE				c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROSEAU 60x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROSE Middle MARIE Last OLSON				4. DATE OF DEATH Month June Day 25 Year 19 56			
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-23-58	9. AGE (In years last birthday) 18 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert S. Olson				14. MOTHER'S MAIDEN NAME Deceased and unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 6-18-56 to present		17. INFORMANT Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DIABETES MELLITUS 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-25-56 , 19 56 , to 6-25-- , 19 56 , that I last saw the deceased alive on 6-25 , 19 56 , and that death occurred at 12:07 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital Bainbridge, Maryland DATE SIGNED 6-25-56							
ACTUAL SIGNATURE J. M. Plukas M.D.				U. S. Naval Hospital Bainbridge, Maryland			
PHYSICIAN'S NAME (Type) J. M. PLUKAS, LT MC USNR							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial		22b. DATE THEREOF 6-27-56		22c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery		22d. LOCATION (City, town, or county) (State) Warroad, Roseau Co., Minn.	
23. FUNERAL DIRECTOR'S SIGNATURE W. A. Patterson & Son, Perryville, Md.				24a. REC'D BY REGISTRAR DATE 6-25-56		24b. REGISTRAR'S SIGNATURE D. Bramble	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. M.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06076

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY New Castle			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS 300 Ashley Road			
3. NAME OF DECEASED (Type or print) First Middle Last James Frederick Robinson				4. DATE OF DEATH Month Day Year June 22 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-19-1895			
9. AGE (In years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		11. BIRTHPLACE (State or foreign country) Cecil, Maryland			
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Fred S. Robinson		14. MOTHER'S MAIDEN NAME Sadie Culp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 221-24-4013		17. INFORMANT Mrs. Katherine Robinson, 300 Ashley Rd., Newark, Delaware			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Penetrating bullet wound in left side of Head DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Shot self with a .22 rifle							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with a .22 rifle					
20c. TIME OF INJURY Month, Day, Year 1:00 p. m. 6-22-1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			
20f. (City or town) Newark, New Castle, Delaware		20g. (County) New Castle					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE R. C. Dodson		EXAMINER'S NAME (Type) R. C. Dodson,		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/56		22c. NAME OF CEMETERY OR CREMATORY St. Georges Cemetery			
22d. LOCATION (City, town, or county) St. Georges Delaware		22e. (State) Delaware					
23. FUNERAL DIRECTOR'S SIGNATURE E. J. Daniels Middletown Del.		24a. REC'D BY REGISTRAR DATE 6/25/56		24b. REGISTRAR'S SIGNATURE J. R. Frazer			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of the Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF NURSE		18. SIGNATURE OF CHAPLAIN		19. SIGNATURE OF MINISTER		20. SIGNATURE OF OTHER	
21. SIGNATURE OF JUDGE		22. SIGNATURE OF CLERK		23. SIGNATURE OF SHERIFF		24. SIGNATURE OF DEPUTY SHERIFF		25. SIGNATURE OF JURY	
26. SIGNATURE OF DISTRICT ATTORNEY		27. SIGNATURE OF COUNTY CLERK		28. SIGNATURE OF TOWNSHIP CLERK		29. SIGNATURE OF VILLAGE CLERK		30. SIGNATURE OF CITY CLERK	
31. SIGNATURE OF MAYOR		32. SIGNATURE OF COMMISSIONER		33. SIGNATURE OF BOARD OF HEALTH		34. SIGNATURE OF BOARD OF CHARITIES		35. SIGNATURE OF BOARD OF EDUCATION	
36. SIGNATURE OF BOARD OF TRADE		37. SIGNATURE OF BOARD OF AGRICULTURE		38. SIGNATURE OF BOARD OF COMMERCE		39. SIGNATURE OF BOARD OF MINES		40. SIGNATURE OF BOARD OF NAVIGATION	
41. SIGNATURE OF BOARD OF RAILROADS		42. SIGNATURE OF BOARD OF STEAMBOATS		43. SIGNATURE OF BOARD OF TRAMWAYS		44. SIGNATURE OF BOARD OF TROLLEYS		45. SIGNATURE OF BOARD OF UTILITIES	
46. SIGNATURE OF BOARD OF WATERWORKS		47. SIGNATURE OF BOARD OF SEWERAGE		48. SIGNATURE OF BOARD OF SANITATION		49. SIGNATURE OF BOARD OF FIREWORKS		50. SIGNATURE OF BOARD OF EXPLOSIVES	
51. SIGNATURE OF BOARD OF MINES		52. SIGNATURE OF BOARD OF COMMERCE		53. SIGNATURE OF BOARD OF NAVIGATION		54. SIGNATURE OF BOARD OF RAILROADS		55. SIGNATURE OF BOARD OF STEAMBOATS	
56. SIGNATURE OF BOARD OF TRAMWAYS		57. SIGNATURE OF BOARD OF TROLLEYS		58. SIGNATURE OF BOARD OF UTILITIES		59. SIGNATURE OF BOARD OF WATERWORKS		60. SIGNATURE OF BOARD OF SEWERAGE	
61. SIGNATURE OF BOARD OF SANITATION		62. SIGNATURE OF BOARD OF FIREWORKS		63. SIGNATURE OF BOARD OF EXPLOSIVES		64. SIGNATURE OF BOARD OF MINES		65. SIGNATURE OF BOARD OF COMMERCE	
66. SIGNATURE OF BOARD OF NAVIGATION		67. SIGNATURE OF BOARD OF RAILROADS		68. SIGNATURE OF BOARD OF STEAMBOATS		69. SIGNATURE OF BOARD OF TRAMWAYS		70. SIGNATURE OF BOARD OF TROLLEYS	
71. SIGNATURE OF BOARD OF UTILITIES		72. SIGNATURE OF BOARD OF WATERWORKS		73. SIGNATURE OF BOARD OF SEWERAGE		74. SIGNATURE OF BOARD OF SANITATION		75. SIGNATURE OF BOARD OF FIREWORKS	
76. SIGNATURE OF BOARD OF EXPLOSIVES		77. SIGNATURE OF BOARD OF MINES		78. SIGNATURE OF BOARD OF COMMERCE		79. SIGNATURE OF BOARD OF NAVIGATION		80. SIGNATURE OF BOARD OF RAILROADS	
81. SIGNATURE OF BOARD OF STEAMBOATS		82. SIGNATURE OF BOARD OF TRAMWAYS		83. SIGNATURE OF BOARD OF TROLLEYS		84. SIGNATURE OF BOARD OF UTILITIES		85. SIGNATURE OF BOARD OF WATERWORKS	
86. SIGNATURE OF BOARD OF SEWERAGE		87. SIGNATURE OF BOARD OF SANITATION		88. SIGNATURE OF BOARD OF FIREWORKS		89. SIGNATURE OF BOARD OF EXPLOSIVES		90. SIGNATURE OF BOARD OF MINES	
91. SIGNATURE OF BOARD OF COMMERCE		92. SIGNATURE OF BOARD OF NAVIGATION		93. SIGNATURE OF BOARD OF RAILROADS		94. SIGNATURE OF BOARD OF STEAMBOATS		95. SIGNATURE OF BOARD OF TRAMWAYS	
96. SIGNATURE OF BOARD OF TROLLEYS		97. SIGNATURE OF BOARD OF UTILITIES		98. SIGNATURE OF BOARD OF WATERWORKS		99. SIGNATURE OF BOARD OF SEWERAGE		100. SIGNATURE OF BOARD OF SANITATION	

RECEIVED
JUN 26 1956
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6087

CERTIFICATE OF DEATH

06077

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.				c. LENGTH OF STAY IN 1b 12yrs8mo.11days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 4707 Tuckerman Street,			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle E. Last SINGER				4. DATE OF DEATH Month June Day 22 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-27-91	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician				10b. KIND OF BUSINESS OR INDUSTRY Orchestra		11. BIRTHPLACE (State or foreign country) New York City, N.Y.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Morris Singer				14. MOTHER'S MAIDEN NAME Minerva Levine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes.				16. SOCIAL SECURITY NO. 1-13-15 8-31-20 Unknown		17. INFORMANT Veterans Administration Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, right lower lobe, unresolved DUE TO (b) Subacute bacterial endocarditis with vegetations DUE TO (c) in aortic cusps Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. INTERVAL BETWEEN ONSET AND DEATH 5-6 days unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Encephalomalacia, left temporal lobe. Arteriosclerosis, general, severe							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10-11- 1943 , to 6-22- 19 56 , that I last saw the deceased alive , and that death occurred at 1:50P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Perry Point, Md. DATE SIGNED 6-25-56 ACTUAL SIGNATURE W. Oppler M.D. Director, Professional Services PHYSICIAN'S NAME (Type) W. OPPLER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-24-56		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James E. Dougherty				ADDRESS Harre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 6-25-56	
24b. REGISTRAR'S SIGNATURE James E. Dougherty							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Religion		Marital Status		Place of Birth		Date of Death		Time of Death		Cause of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		45		Male		White		Catholic		Married		New York City, N.Y.		1955-07-21		10:30 AM		Heart Disease		Home		[Signature]		[Signature]	
Occupation		Education		Date of Birth		Date of Death		Time of Death		Cause of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Cause of Death		Place of Death	
Teacher		High School		1910-03-15		1955-07-21		10:30 AM		Heart Disease		Home		[Signature]		[Signature]		1955-07-21		10:30 AM		Heart Disease		Home	

BUREAU V. S.
JUN 27 1956
RECEIVED

Amey [Signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film 199 6-25-56

CERTIFICATE OF DEATH

06078

96

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, c. LENGTH OF STAY IN 1b 3 mo. 5 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS c/o Parkside Hotel e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ERNEST Middle E. Last SPEAK		4. DATE OF DEATH Month June Day 11 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> (Separated) WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-19-82
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73	IF UNDER 24 HRS. Days 73 Hours 73 Min. 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Locomotive	
11. BIRTHPLACE (State or foreign country) New Mexico		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Speak		14. MOTHER'S MAIDEN NAME Margaret (?)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) unknown	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, unresolved, left lower lobe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of undetermined origin with metastasis to the right adrenal and left lung (c) Arteriosclerosis, general			INTERVAL BETWEEN ONSET AND DEATH 36-48 hours unknown unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 6 , 19 56 , to June 11 , 19 56 , and that death occurred at 5:43 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Perry Point, Md. DATE SIGNED 6-13-56			
ACTUAL SIGNATURE W. M. HARRIS		M.D. VAH, Perry Point, Md.	
PHYSICIAN'S NAME (Type) W. M. HARRIS		Actg. Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 6-13-56	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Harwood Grace, Md.		ADDRESS Harwood Grace, Md.	
24a. REC'D BY REGISTRAR DATE 6-15-56		24b. REGISTRAR'S SIGNATURE Irene E. Dougherty	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

BUREAU V. S.

JUN 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06079

Reg. Dist. No. 96

6239

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 1 mo. 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 114 Bay Boulevard			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First VIRGIL Middle O. Last SPENCER		4. DATE OF DEATH Month June Day 19 Year 19 56					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-18-23	9. AGE (In years last birthday) 32 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Explosive		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ira Spencer				14. MOTHER'S MAIDEN NAME Bessie Bennett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 236-26-7487		17. INFORMANT Hospital Records, VAH, Perry Point, Md.			
		(If yes, give war or dates of service) WW II					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest (after surgery) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Benign pulmonary cyst DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 12 hours unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that x attended the deceased from May 11 , 19 56 , to June 19 , 19 56 , and that death occurred at 7:00 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Oppler				ADDRESS (Street, city or town, state) VAH, Perry Point, Md.		DATE SIGNED 6-20-56	
PHYSICIAN'S NAME (Type) W. OPPLER				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-19-56		22c. NAME OF CEMETERY OR CREMATORY Walnut Grove		22d. LOCATION (City, town, or county) (State) Dille, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Pannington & Son				ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 6-20-56	
				24b. REGISTRAR'S SIGNATURE Inez E. Daugherty			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2000

NAME OF DECEASED		SEX		AGE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		Male		65		1956		Home	
MARRIAGE		SINGLE		EDUCATION		OCCUPATION		RELIGION	
None		None		High School		None		None	
BIRTH		DATE		PLACE		MOTHER'S NAME		FATHER'S NAME	
1900		10-10-1890		Maryland		Maryland		Maryland	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL		DATE OF BURIAL		NAME OF BURIAL PLACE	
Heart Disease		Natural		Catholic Cemetery		1956		Catholic Cemetery	
CERTIFICATE OF DEATH		MAY 1956		JAMES H. HARRIS		1956		Catholic Cemetery	

BUREAU V. S.

JUN 22 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06080

Reg. Dist. No. 96

6093

1. PLACE OF DEATH a. COUNTY <u>Becil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Becil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>39 N. Main St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HOWARD MORRISON STROUT</u>		4. DATE OF DEATH Month <u>6</u> Day <u>17</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10-7-1884</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired and Sgt. Panchang</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Port Deposit Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U S C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S C.</u>	
13. FATHER'S NAME <u>Theodore H. Strout</u>		14. MOTHER'S MAIDEN NAME <u>Kate L. Morrison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-03-3444</u>	
17. INFORMANT <u>Ray Down</u>		Address <u>39 Main St. Port Deposit Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cerebral</u>			
DUE TO <u>Hemorrhage.</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R. C. Dodson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. C. DODSON</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-20-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham</u>		22d. LOCATION (City, town, or county) (State) <u>Coloma, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Patterson + Son</u>		ADDRESS <u>Perryville, Md.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Inez E. Daugherty</u>	
DATE <u>6-20-56</u>		DATE SIGNED <u>6-17-56</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUN 21 1956

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6091

CERTIFICATE OF DEATH

06081

Reg. Dist. No. 95

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Cecil	MARYLAND	STATE Md.	COUNTY Cecil
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rising Sun	LENGTH OF STAY (in this place) 30 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rising Sun	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED		4. DATE OF DEATH	
(First) Mary	(Middle) Ethel	(Last) Wilson	(Month) June (Day) 11 (Year) 56
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH July 8 1889
9. AGE last birthday 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Port Deposit Rural		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Hall		14. MOTHER'S MAIDEN NAME Priscilla Kyle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT & ADDRESS Howard Wilson Rising Sun Md.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		3 years	
199.8 IMMEDIATE CAUSE (A) Metastatic Carcinoma of the			
ANTECEDENT CAUSE(S) DUE TO femur and Brain.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 1, 1955, to June 10, 1956, that I last saw the deceased alive on June 10, 1956, and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
SIGNATURE H. L. Dodson		DATE SIGNED 6-12-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. REC'D BY REGISTRAR June 12-56	
DATE THEREOF June 14, 1956		NAME OF CEMETERY OR CREMATORY Brookview Cem.	
LOCATION (City, town, or county) Rising Sun		ADDRESS Md.	
25. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson		ADDRESS Rising Sun, Md.	

CERTIFICATE OF DEATH

8031

DEATH RECORD NUMBER OF NEW YORK

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

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BUREAU V. 2

JUN 13 1956

RECEIVED

1956 JUN 13 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0608291

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Earville</u>		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton, R.D. 4</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Eleanor</u> First <u>Jean</u> Middle <u>Wooleyhan</u> Last				4. DATE OF DEATH Month <u>6-26</u> Day <u>19</u> Year <u>56</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>8-15-1932</u>		9. AGE (In years last birthday) <u>23</u> yrs.		IF UNDER 1 YEAR: Months <u>23</u> Days <u>23</u> Hours <u>23</u> Min. <u>23</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House keeping</u>		11. BIRTHPLACE (State or foreign country) <u>Earlville. Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Emerson Loller</u>			
14. MOTHER'S MAIDEN NAME <u>Mary Louise Matthews</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT Address <u>Emerson Loller, Earlville. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage from Gastric Ulcer</u> <u>540.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Gall Stone Operation</u> (c), stating the underlying cause lost. DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>o. m.</u> <u>p. m.</u>					
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>R. C. Dodson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>				DATE SIGNED <u>6-27-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-29-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cecil Cem.</u>			
22d. LOCATION (City, town, or county) (State) <u>Cecil Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward J. Taylor</u> ADDRESS <u>Millington Md.</u>					
24a. REC'D BY REGISTRAR <u>Mr. Ralph Reed</u>		24b. REGISTRAR'S SIGNATURE <u>Mr. Ralph Reed</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU A. B.

1956 JUL 3

RECEIVED